APPEAL NO. 93501

On April 16, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issue determined at the contested case hearing was the correct impairment rating assigned to the claimant, Ms L, whose married name is Ms L, the respondent in this appeal. Claimant sustained an injury on (date of injury), while employed by (employer).

The hearing officer adopted the report of the designated doctor that claimant had 24% impairment rating. Maximum medical improvement (MMI) was not in dispute, and the designated doctor did not denominate a date of MMI; the hearing officer consequently used the date of MMI determined by the treating doctor. The hearing officer, noting that the treating doctor had changed his first impairment rating, stated that the application of the 90-day rule was moot.

The carrier has appealed, arguing that the evidence was that the first impairment rating assigned by the treating doctor was undisputed and therefore became final. The carrier takes issue with numerous fact findings, and puts forward others that it feels should have been made. The carrier argues that there is no requirement that an impairment rating be in writing in order to be disputed. The carrier does not argue that the designated doctor's report is contrary to the great weight of other medical evidence. Although there is no indication in the record that carrier has ever disputed that its liability is limited because of a subsequent injury, the carrier now points out that claimant had opportunity to aggravate her injury when she resumed employment with another employer. The claimant responds that the decision of the hearing officer should be upheld.

DECISION

After reviewing the record, we affirm the hearing officer's decision with modification to his reasoning.

The claimant testified for herself; the adjuster for the carrier, (Mr. P), testified for the carrier. The claimant injured her back and was referred by her company doctor to (Dr. S), who became her treating doctor. Dr. S operated on claimant's back the Saturday after Thanksgiving 1991 for a herniated disc. An MRI dated November 25, 1991, indicated that claimant had a paracentral disc herniation at L5-S1 to the right of midline. The claimant said that Dr. S told her in January that if she didn't get better, she might need surgery again. However, on March 5, 1992, according to a TWCC-69 and narrative report of that date, Dr. S stated that claimant had improved. Dr. S released claimant to light work with restrictions, noting that she would be at increased risk for reinjury. However, he did not recommend further surgery. Dr. S filed a TWCC-69 asserting that claimant reached MMI effective March 5, 1992, with a 12% whole body impairment rating. Claimant stated that she never received or saw a copy of this report until December 1992, after the dispute over impairment arose. The adjuster, Mr. P, could not testify exactly when he received a copy of the report, although he felt it was within a month. The copy of Dr. S's report which is in evidence has a large "F" written over each page; the narrative report contains a hand-written date of "4-

29-92." No copy of the document reporting the first payment of IIBS was entered into evidence.

The claimant agreed that Dr. S verbally told her that her "disability" would be 12%. The claimant could not recall if this conversation occurred in March or April of 1992. The claimant and Mr. P both testified that claimant called Mr. P to tell him that Dr. S intended to give her a 12% rating. Mr. P recalled this as March 5, 1992. Both persons testified that they discussed when the temporary income benefits (TIBS) would end, and the impairment income benefit (IIBS) would begin. Mr. P stated to claimant that he would begin payment of IIBS when he received Dr. S's report.

The claimant said that she resumed work for another employer in April 1992, which she quit in June 1992 due to demands that she work overtime. She testified that her duties there did not require lifting of anything more than a single sheet of large paper, although initially she worked overtime, which was stressful. The claimant said in July 1992 she went back to Dr. S (whether as follow-up or because of continued pain is not developed in the record) and was told at that time that she would definitely need surgery. The claimant stated that this caused her, for the first time, to question the accuracy of the rating she had been given, because she didn't understand how, if she now needed surgery, she could only have a 12% impairment. The claimant immediately called the Commission and was told that she could dispute the rating. She indicated her dispute. On July 13, 1992, Disability Determination Officer Amparo Martinez wrote the claimant and carrier that notice of a dispute had been received, and that if the parties could not agree upon a designated doctor, one would be appointed.

Thereafter, the Commission appointed (Dr. O), who conducted a five-hour examination of claimant on August 28, 1992 (the date listed on his report). Claimant stated that Dr. O ordered an MRI, and that she returned (on September 10, 1992, according to Dr. O's report) for his final evaluation. The MRI indicates a "residual or recurrent" right-sided herniation of the disc at L5-S1. The claimant stated that Dr. O told her that she either reinjured herself or that her first injury had not been repaired by her November 1991 surgery. He assigned a 24% impairment rating, checking on the TWCC-69 that claimant had reached MMI. However, Dr. O put "no comment" in the date of MMI. The claimant stated that the carrier did not indicate disagreement with Dr. O's report as far as she was aware, and that they paid for Dr. O as far as she knew. She indicated that she assumed her impairment rating would be 24% according to his report, and was surprised when her checks stopped on an unspecified date in November 1992. She learned at that time, through the disability determination officer, that the carrier was now claiming that her first impairment rating was final because of a 90-day rule. Claimant stated that she did not know about a 90-day rule.

The claimant changed treating doctors to (Dr. R), who issued a letter dated November 23, 1992, which agreed with Dr. O's impairment rating.

Apparently as a result of the recommendation of the benefit review officer,[1] Dr. S reconsidered his impairment rating. The claimant stated that Dr. S told her that, if she wanted, he could say she had not reached MMI, but she indicated to him that she wanted to return to work and did not therefore want him to say this. Dr. S subsequently filed a TWCC-69 stating that claimant reached MMI January 7, 1993, with a 17% impairment rating. While Dr. S concedes that there "could" be a recurrent disc herniation, he stated that he could not make a clinical diagnosis of recurrent herniation. He disputed the accuracy of Dr. O's 24% rating, and Dr. R's agreement with it. Dr. S noted at the beginning of his report that there was a controversy regarding his 12% rating versus the 24% rating.

Mr. P testified that he was contacted by the disability determination officer in July 1992, and told that the Commission intended to appoint a designated doctor, and that he at that time protested on the basis of the 90-day rule. Mr. P said that the disability determination officer told him he could raise this at "the BRC." He stated that he had no documentary evidence to prove that he raised the 90 day defense in July, and conceded that he did not request a BRC at that time. There is no evidence in the record that a BRC had been scheduled at the time of the purported conversation in July.

The claimant detailed three main reasons for not raising a dispute in 90 days: she had no medical reason to dispute the rating Dr. S told her until July 1992, she did not know about the 90-day rule, and that she had not received a written report. The hearing officer's determination that MMI was reached May 7, 1992, has not been appealed by either party.

The report of a designated doctor on impairment must be given presumptive weight unless the great weight of other medical evidence is to the contrary. Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-4.26(g). The designated doctor is appointed as the impartial doctor to resolve disputes over impairment or MMI. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5 (Rule 130.5(e)) provides that the first impairment rating assigned is considered final if not disputed within 90 days after it is assigned.

We have noted before that the 90 day deadline for disputing an impairment rating

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[1] As noted by the claimant's attorney at the end of the hearing, it is routine for hearing officers to take official notice of the BRC report, which, by rules of the Texas Workers' Compensation Commission (Commission), is the operative document for establishing the issues that may be heard. While matters discussed at the BRC are not sworn and do not constitute a "record," Article 8308-6.13(c) and (d), the positions of the parties as set forth in the BRC report may, in our opinion, be properly considered as indicative of the issues that are before the hearing officer. At the close of this case, there was discussion that the carrier's position reflected on the BRC report may have been that the treating doctor's revised rating (not his initial rating) should be adopted by the Commission. The hearing officer in this case would not take official notice, observing that neither party had offered the BRC report into evidence. In our opinion, it was error for the hearing officer to refuse to officially notice the BRC report, as part of his statutory obligation to ensure the preservation of the rights of the parties. While error, it is harmless error in light of the hearing officer's determination in favor of the claimant. Should the district court, if judicial review is sought, wish to accept the report into evidence, we would note our opinion that the refusal of the hearing officer to include it in the record of our case here should not be used as a basis to exclude the report as evidence in future proceedings.

does not run from the date a doctor issues a report, but from the date the parties become aware of the rating. We noted that it is hard to envision that one could dispute something of which one is not aware. *See* Texas Workers Compensation Commission Appeal No. 92693, decided February 8, 1993. Our decisions involving the 90 day rule have all used some form of written notice as the point at which the 90 day period began. Arguably, notice of an impairment rating is best conveyed through a written report. A written report by the evaluating doctor could raise colorable disputes that a verbal notice would not. For example, the TWCC-69 requires a doctor to indicate how a percentage is calculated. The written report could show a computation error that verbal discussion would not.

The importance of a written report of impairment under the facts of this case is underscored by the testimony of Mr. P, the carrier's adjuster, that carrier would begin payment of IIBS, not based upon claimant's phone call relaying her belief of what the impairment rating would be, but upon receipt of a written report from the doctor. If the hearing officer had, in this case, determined that the 90-day rule did not begin to run because the claimant did not receive Dr. S's written report, such a finding would be supportable. We note that the carrier itself was not prepared to react to only a verbal awareness of Dr. S's anticipated impairment rating. As it stands, this fact sufficiently supports the hearing officer's appealed finding that claimant's call to the adjuster was to notify him of a "pending" impairment rating.

However, whether claimant had written notice is a relative side issue in this case. Of greater substantive importance is the fact that the initial 12% impairment was rendered without knowledge of a recurrent herniated disc and was subsequently revised by the treating doctor upon reviewing new medical information.

Where there is compelling medical evidence that an impairment rating was rendered based upon lack of knowledge of a material change in the claimant's medical condition, a fact finder could determine that the certification was invalid when rendered. There can hardly be more compelling medical evidence than revision of that rating by doctor who originally rendered it. There is sufficient evidence from this fact, coupled with the new MRI showing a residual or recurrent disc herniation at the same site of the prior injury, and Dr. S's July 1992, surgery recommendation to support the hearing officer's determination that the 90-day rule was moot in this case.[2]

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[2] We observe that there is an element of estoppel when both parties allow a dispute to proceed to appointment of a designated doctor, and then much after the fact raise a 90 day defense. The rules of the Commission must be read harmoniously with other rules and statutes. The 1989 Act, Article 8038-4.26, clearly directs the Commission to give presumptive weight to the report of a designated doctor absent a great weight of medical evidence to the contrary. In facts such as these, where the parties allow the designated doctor's examination to proceed without prompt resort to dispute resolution, elevating the "finality" of a revoked impairment rating in this case would arguably be a violation of the presumptive weight which the legislature has directed the Commission to accord to the designated doctor. *See* Article 8308-4.26(g), *in conjunction with* Texas Workers' Compensation Commission Appeal No. 92639, decided January 14, 1993, and Texas Workers' Compensation Commission Appeal No. 93207, decided May 3, 1993.

In Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993, the Appeals Panel noted that there were no "exceptions" to Rule 130.5. It is important to read that statement in the context of that case, however, in which the Appeals Panel also noted the lack of medical information presented by the claimant to establish that the initial impairment rating was wrong. The Appeals Panel has subsequently opined that compelling medical evidence of a new, previously undiagnosed medical condition or improper or inadequate treatment of an injury could render an initial certification of MMI invalid. *See* Texas Workers' Compensation Commission Appeal No. 93489, decided July 29, 1993. In this case, the treating doctor himself, Dr. S, has effectively withdrawn the rating that the carrier seeks to finalize. The MRI examination conducted after Dr. S issued his 12% impairment rating disclosed either that November 1991, surgery may not have corrected the initial injury or that a new condition arose which was not diagnosed by Dr. S when he rendered his 12% rating. Although the carrier argued at the hearing that Dr. S did not "rescind" his original rating, it has offered no cogent alternative explanation of what the 17% rating by Dr. S would be if not a recision or amendment of the original.

As the defense that claimant sustained an aggravated injury during her subsequent employment was not in issue before the hearing officer, we will not address it here.

For these reasons, the determination of the hearing officer is affirmed.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge